

(ix) 1322. Federal program to assist establishment and operation of non-profit, member-run health insurance issuers.

(x) 1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.

(xi) 1334. Multi-State plans.

(xii) 1402. Reduced cost-sharing for individuals enrolling in QHPs.

(xiii) 1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.

(xiv) 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

(xv) 1413. Streamlining of procedures for enrollment through an Exchange and State, Medicaid, CHIP, and health subsidy programs.

(2) This part is based on section 1150A, Pharmacy Benefit Managers Transparency Requirements, of title I of the Act:

(b) *Scope*. This part establishes standards for QHPs under Exchanges, and addresses other health insurance issuer requirements.

§ 156.20 Definitions.

The following definitions apply to this part, unless the context indicates otherwise:

Actuarial value (AV) means the percentage paid by a health plan of the percentage of the total allowed costs of benefits.

Applicant has the meaning given to the term in § 155.20 of this subchapter.

Base-benchmark plan means the plan that is selected by a State from the options described in § 156.100(a) of this subchapter, or a default benchmark plan, as described in § 156.100(c) of this subchapter, prior to any adjustments made pursuant to the benchmark standards described in § 156.110 of this subchapter.

Benefit design standards means coverage that provides for all of the following:

(1) The essential health benefits as described in section 1302(b) of the Affordable Care Act;

(2) Cost-sharing limits as described in section 1302(c) of the Affordable Care Act; and

(3) A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in section 1302(e) of the Affordable Care Act.

Benefit year has the meaning given to the term in § 155.20 of this subtitle.

Cost-sharing has the meaning given to the term in § 155.20 of this subtitle.

Cost-sharing reductions has the meaning given to the term in § 155.20 of this subtitle.

Delegated entity means any party, including an agent or broker, that enters into an agreement with a QHP issuer to provide administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

Downstream entity means any party, including an agent or broker, that enters into an agreement with a delegated entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the delegated entity and the QHP issuer. The term “downstream entity” is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

EHB-benchmark plan means the standardized set of essential health benefits that must be met by a QHP, as defined in § 155.20 of this section, or other issuer as required by § 147.150 of this subchapter.

Essential health benefits package or EHB package means the scope of covered benefits and associated limits of a health plan offered by an issuer that provides at least the ten statutory categories of benefits, as described in § 156.110(a) of this subchapter; provides the benefits in the manner described in § 156.115 of this subchapter; limits cost sharing for such coverage as described in § 156.130; and subject to offering catastrophic plans as described in section 1302(e) of the Affordable Care Act, provides distinct levels of coverage as described in § 156.140 of this subchapter.

Federally-facilitated SHOP has the meaning given to the term in § 155.20 of this subchapter.

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Group health plan has the meaning given to the term in §144.103 of this subtitle.

Health insurance coverage has the meaning given to the term in §144.103 of this subtitle.

Health insurance issuer or issuer has the meaning given to the term in §144.103 of this subtitle.

Issuer group means all entities treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark.

Level of coverage means one of four standardized actuarial values as defined by section 1302(d)(1) of the Affordable Care Act of plan coverage.

Percentage of the total allowed costs of benefits means the anticipated covered medical spending for EHB coverage (as defined in §156.110(a) of this subchapter) paid by a health plan for a standard population, computed in accordance with the plan's cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.

Plan year has the meaning given to the term in §155.20 of this subchapter.

Qualified employer has the meaning given to the term in §155.20 of this subchapter.

Qualified health plan has the meaning given to the term in §155.20 of this subchapter.

Qualified health plan issuer has the meaning given to the term in §155.20 of this subchapter.

Qualified individual has the meaning given to the term in §155.20 of this subchapter.

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§ 156.50 Financial support.

(a) *Definitions.* The following definitions apply for the purposes of this section:

Participating issuer means any issuer offering a plan that participates in the specific function that is funded by user

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fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in §155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in §155.1065 of this subtitle), or other issuers identified by an Exchange.

(b) *Requirement for State-based Exchange user fees.* A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by a State-based Exchange under §155.160 of this subchapter.

(c) *Requirement for Federally-facilitated Exchange user fee.* To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.

(d) *Adjustment of Federally-facilitated Exchange user fee—*(1) A participating issuer offering a plan through a Federally-facilitated Exchange may qualify for an adjustment in the Federally-facilitated Exchange user fee specified in paragraph (c) of this section to the extent that the participating issuer—

(i) Made payments for contraceptive services on behalf of a third party administrator pursuant to 26 CFR 54.9815–2713A(b)(2)(ii) or 29 CFR 2590.715–2713A(b)(2)(ii); or

(ii) Seeks an adjustment in the Federally-facilitated Exchange user fee with respect to a third party administrator that, following receipt of a copy of the self-certification referenced in 26 CFR 54.9815–2713A(a)(4) or 29 CFR 2590.715–2713A(a)(4), made or arranged for payments for contraceptive services pursuant to 26 CFR 54.9815–2713A(b)(2)(i) or (ii) or 29 CFR 2590.715–2713A(b)(2)(i) or (ii).

(2) For a participating issuer described in paragraph (d)(1) of this section to receive the Federally-facilitated Exchange user fee adjustment—